XEROX EDI GATEWAY, INC.

ANSI ASC X12N V5010 837 HEALTH CARE CLAIM INSTITUTIONAL
COLORADO MEDICAL ASSISTANCE PROGRAM
DEPARTMENT OF HEALTH CARE POLICY AND FINANCING (DHCPF)
COMPANION GUIDE

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XEROX EDI GATEWAY, INC.

ANSI ASC X12N V5010 837
Health Care Claim Institutional
Colorado Medical Assistance Program
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Chapter 1 Introduction

Scope

This Companion Guide is intended for trading partner use in conjunction with the *ASC X12 Technical Report Type 3 (TR3), Health Care Claim: Institutional 837*. The TR3 can be accessed at http://www.wpc-edi.com/. This guide outlines the procedures necessary for engaging in Electronic Data Interchange (EDI) with Xerox EDI Gateway, Inc. and specifies data clarification where applicable.

Overview

Xerox EDI Gateway, Inc., a leader in health care technology, provides EDI gateway services to providers enrolled in contracted health care plans. Our electronic transactions acquisition services provide an array of tools that allow you to:

- Easily submit all of your transactions to one source
- Submit transactions twenty-four hours a day, seven days a week
- Receive confirmation of receipt of each file transferred

Health care plans that participate with Xerox EDI Gateway, Inc. are referred to as payers. Transactions are accepted electronically into our data center and processed. As an EDI gateway service, we provide connectivity to various health care plans and states where Xerox EDI Gateway, Inc. is the fiscal agent, third-party administrator, or contracted clearinghouse.

Chapter 2 Transmission Methods

Trading partners are offered the following transmission methods:

Asynchronous Dial-Up

Xerox EDI Gateway provides an interactive, menu-driven Host Data Exchange System (HDE) that allows you to upload your transaction files and receive immediate confirmation of the status of your transfer. The HDE can be accessed using a standard modem and supports modem speeds of up to 56,000 BPS. Transaction transmission is available twenty-four hours a day, seven days a week. This availability is subject to scheduled and unscheduled downtime. It is operational policy to schedule preventative maintenance periods on weekends whenever possible.

Communication Protocols

Xerox currently supports the following asynchronous dial-up communication options:

XMODEM, YMODEM, ZMODEM, Kermit

Teleprocessing Requirements

The general specifications for asynchronous dial-up communication with Xerox are:

Telecommunications	Hayes-compatible 2400-56K BPS asynchronous modem.
File Format	ASCII text data.
Compression Techniques	PKZIP will compress one or more files into a single ZIP archive. WINZIP will compress one or more files into a single ZIP archive. Xerox accepts transmission with any of the above compression techniques, as well as non-compression files.
Data Format	8 data bit, 1stop bit, no parity, full duplex.

Transmission Protocol	ZMODEM uses 128 byte to 1024 byte variable packets and a 16-bit or 32-bit Cyclical Redundancy Check (CRC). XMODEM uses 128 byte blocks and a 16-bit CRC. YMODEM uses 1024 byte blocks and a 16-bit CRC. KERMIT can be accepted if X, Y, or ZMODEM capabilities are not available with your communication software.

Teleprocessing Settings

ASCII Sending	Send line ends with line feeds (should not be set). Echo typed characters locally (should not be set). Line delay 0 milliseconds. Character delay 0 milliseconds.
ASCII Receiving	Append line feeds to incoming line ends should not be checked. Wrap lines that exceed terminal width.
Terminal Emulation	VT100 or Auto.

Transmission Procedures

SUBMITTER	HOST SYSTEM
1. Dials Xerox Host	Answers call, negotiates a common baud rate, and sends to the trading partner: **"Please enter your Login=>"**
2. Enters Login Name <CR>	Receives User Name (Login Name) and sends to the trading partner: **"Please enter your password=>"**
3. Enters Password <CR>	Receives Login and verifies if trading partner is an authorized user: Sends HOST selection menu followed by a user prompt: **"Please Select from the Menu Options Below =>"**
4. Enters Desired Selection <CR>	**#1. Electronic Claims Submission:** Assigns and sends the transmission file name then waits for ZMODEM (by default) file transfer to be initiated by the trading partner. **#2. View Submitter Profile** Allows submitters to view the transaction types for which they are currently enrolled. **#3. Select File Transfer Protocol:** Allows submitters to change the protocol for the current submission only. The protocol may be changed to **(K)**ermit, **(X)**Modem, **(Y)**Modem, or **(Z)**Modem. Enter the first letter of the protocol that you wish to use. Enter selection **(K, X, Y, Z):** **#4. Download Confirmation**

	Allows submitters to download confirmation reports. **#9. Exit & Disconnect:** Terminates connection.
5. Enters "1" to send file <CR>	Receives ZMODEM (or other designated protocol) file transfer. Upon completion, initiates file confirmation. Sends file confirmation report. Sends HOST selection menu followed by a user prompt=>

For Transmission Phone numbers please refer to Chapter 6.

Interactive Transmissions

Interactive transmission may be submitted through the State's Provider Web Portal. The State's Provider Web Portal will include a File and Reports Service (FRS) for file and report retrieval. For information on the State's Provider Web Portal, go to the Provider Services Web Portal section of the Department's Web site at http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1201542697178.

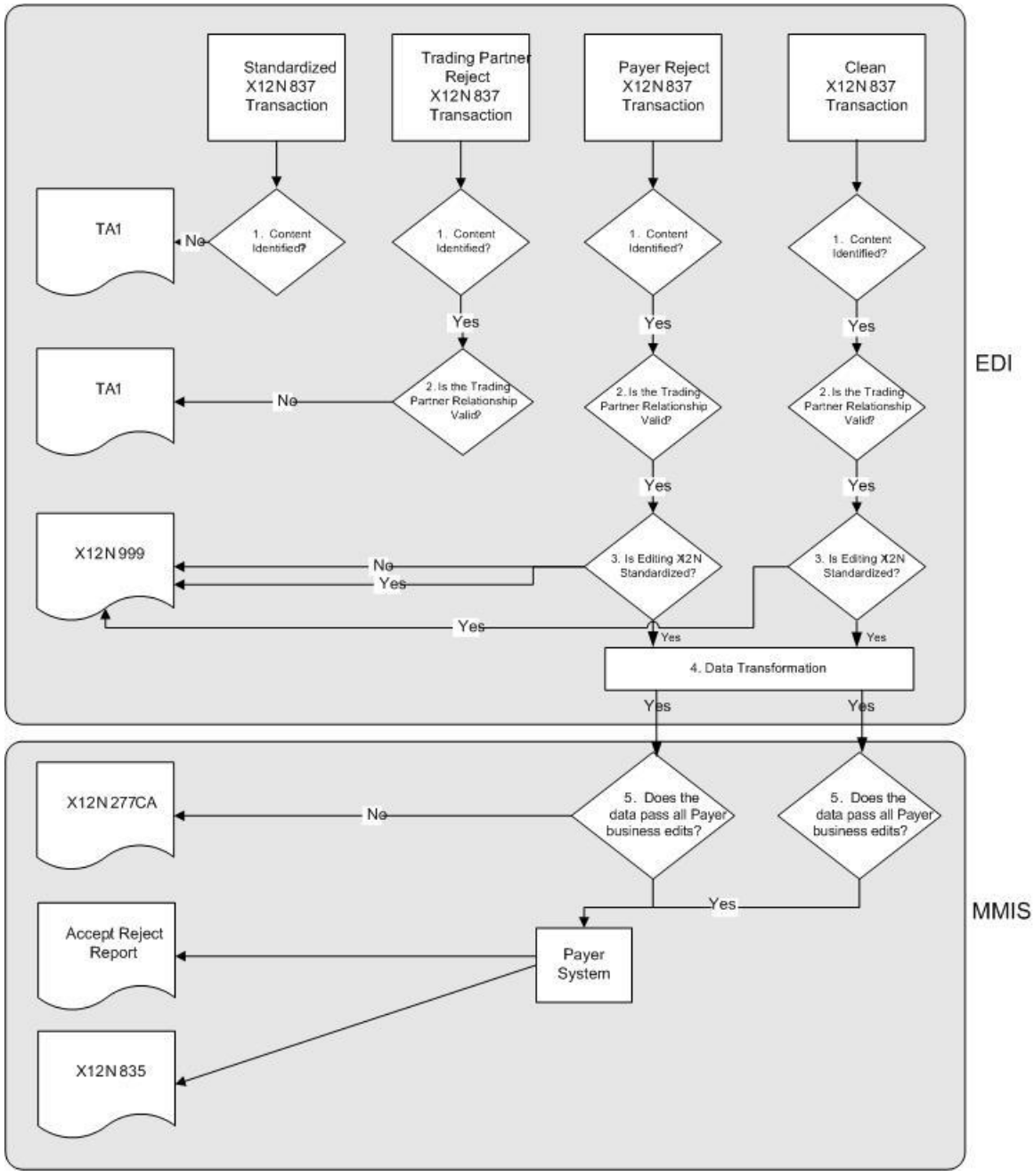
Chapter 3 Transmission Responses

The X12N 837 Institutional transaction data will be submitted to Xerox EDI Gateway for processing. The Xerox clearinghouse validates submission of ANSI X12N format(s). The TA1 Interchange Acknowledgement reports the syntactical analysis of the interchange header and trailer. If the data is corrupt or the trading partner relationship does not exist within the Gateway system, the interchange will reject and a TA1 along with the data will be forwarded to a Xerox Business Analyst for review and follow-up with the sender.

An X12N 999 Functional Acknowledgement is generated when a file that has passed the header and trailer check passes through the clearinghouse. If the file contains syntactical error(s), the segment(s) and element(s) where the error(s) occurred will be reported.

After validation, the Xerox clearinghouse will return the X12N 835 Remittance Advice containing information related to payees, payers, dollar amount and payments. The X12N 835 transactions will be returned to the Colorado Medical Assistance Program File and Reports Services for retrieval by the trading partner.

Editing and Validation Flow Diagram



LEGEND:

1. **Content Identification:** Data identification is attempted. If the data is corrupt or intended for another resource, a TA1 (Interchange Acknowledgement) is forwarded to the Xerox clearinghouse call center for review and follow-up with the submitter. If the data can be identified, it is checked for trading partner relationship validation.

2. **Trading Partner Relationship Validation:** The trading partner information is validated. If it is invalid, a TA1 (Interchange Acknowledgement) will be forwarded to the Xerox clearinghouse call center for review and follow-up with the submitter. If the trading partner relationship is valid, the data will be passed for X12N syntax validation.
3. **X12N Syntax Validation:** A determination will be made as to whether the data is ANSI ASC X12N. An X12N 999, Implementation Acknowledgement, will be returned to the submitter containing either **ACCEPT** or **REJECT** information. If the file contained syntactical errors, the segment(s) and element(s) where the error(s) occurred will be reported. If the data passes X12N syntax validation, payer business edits will be performed.
4. **Data Processed:** The data is processed and an Accept/Reject Report is returned after a pre-adjudication is performed. After the full adjudication cycle is complete, an ANSI ASC X12N 835 will be returned to the File and Reports Service for submitter pickup.
5. **Payer Business Edits:** Data is edited on the front-end. If the data does not pass this edit level, an X12N 277CA (Claim Acknowledgement) is sent detailing errors. If the data passes this level, it proceeds to the payer system for processing. An X12N 277CA Report is generated and sent to the File and Reports Service for submitter retrieval.

Transmission Errors and Reports

HIPAA not only gave the health care community the ability to standardize transactions, but also the ability to standardize front-end edits and the acceptance/rejection reports associated with the edits. The acceptance/rejection reports pertain to precision within EDI transaction format syntax and transaction TR3 compliance. When a report is generated, the type of report returned is dependent on the edit level that is invalid.

A transaction contains three levels where edits are present. The edit level the error occurs in designates rejection of an entire batch or a single claim.

The three levels are:

- Interchange Level Errors
  - ISA and IEA
- Functional Group Level Results
  - GS and GE
- Transaction Set Level Syntax Results
  - ST and SE

In the description below, the three levels and their affiliated acceptance/rejection reports are discussed.

Interchange Level Errors and TA1 Rejection Report

This edit is enforced by interchange level problems. These edit check the ISA and IEA level segments and the data content within these segments, which consist of the header and footer batch information. Any X12N syntax error that occurs at this level will result in the entire transaction being rejected. These rejections are reported on a TA1. In some cases, an error in the GS and GE can initiate a TA1 rejection. This will occur if the GS and GE envelope cannot be identified.

TA1-Interchange Acknowledgement

A TA1 is an ANSI ASC X12N Interchange Acknowledgement segment used to report receipt of individual interchange envelopes. An interchange envelope contains the sender, receiver, and data type information within the header. The TA1 reports the syntactical analysis of the interchange header and trailer. If invalid (e.g., the data is corrupt or the trading partner relationship does not exist within the Xerox system) the interchange will reject and a TA1, along with the data, will be forwarded to the Xerox EDI Gateway technical support for review and follow-up with the submitter.

EXAMPLE:

The transaction was built with incorrect Interchange Control Number at the end of the transaction. Control Number for IEA01 does not match with ISA11

ISA*03* *00* *ZZ*100000 *ZZ*100000 *111026*1015*^*00501***00905***0*T*:~

GS*HC*100000*77016*20111026*101507*284101503*X*005010X223A2~

ST*837*284101503*005010X223A2~
NM1*PR*2*CO Medicaid*****PI*77016~
HL*1**20*1~
NM1*85*2* ABDSERVICE *****24*587654321~
HL*2*1*21*1~
NM1*IL*1*Doe*John****34*0002211~
HL*3*2*22*1~
HI*BF:41090:D8:20030908*1101~
NM1*IL*1*Smith*Joe****MI*12345678901~
HL*4*3*19*1~
NM1*SJ*1*Watson*Susan****34*987654321~
PER*IC**TE*4029993456~
SE*12*0001~

ST*837*0001~
NM1*PR*2*CO Medicaid*****PI*77016~
HL*1**20*1~
NM1*85*2* ABDSERVICE *****24*587654321~
HL*2*1*21*1~
NM1*IL*1*Doe*John****34*0002211~
HL*3*2*22*1~
HI*BF:41090:D8:20030908*1101~
NM1*IL*1*Smith*Joe****MI*12345678901~
HL*4*3*19*1~
NM1*SJ*1*Watson*Susan****34*987654321~
PER*IC**TE*4029993456~
SE*184*284101503~

GE*1*284101503~

IEA*1***00095**~

For additional information regarding the TA1, please refer to Appendix B in the ANSI ASC X12N *Consolidated Guide Health Care Claim: Institutional (837).*

Functional Group Level Errors and 999 Rejection Report

Xerox clearinghouse validates submission of ANSI ASC X12N format(s). An ANSI ASC X12N 999, or Functional Acknowledgement, is generated when an EDI file, e.g., an ANSI ASC X12N file that has passed the header and trailer check, passes through the clearinghouse. The X12N 999 **REJECT** is generated if the file contained syntactical errors. The segment(s) and element(s) where the error(s) occurred will be reported. For an example of this report, please see *ASC X12 TR3, Implementation Acknowledgment for Health Care Insurance (999).* Trading Partner Agreement between Xerox EDI Gateway and the trading partners requires this method of acknowledgement.

EXAMPLE:

The transaction was built with incorrect Total Number of transaction sets at the Functional Group Trailer. GE01 should be 2 as Functional Group contains two GS to GE transactions.

ISA*03* *00* *ZZ*100000 *ZZ*100000 *111026*1015*^*00501*00905*0*T*:~

GS*HC*100000*77016*20111026*101507*284101503*X*005010X223A2~

ST*837*284101503*005010X223A2~
NM1*PR*2*CO Medicaid*****PI*77016~
HL*1**20*1~
NM1*85*2* ABDSERVICE *****24*587654321~
HL*2*1*21*1~
NM1*IL*1*Doe*John****MI*Z002211~
HL*3*2*22*1~
HI*BF:41090:D8:20030908*1101~
NM1*IL*1*Smith*Joe****MI*12345678901~
HL*4*3*19*1~
NM1*SJ*1*Watson*Susan****34*987654321~
PER*IC**TE*4029993456~
SE*12*0001~

ST*837*0001~
NM1*PR*2*CO Medicaid*****PI*77016~
HL*1**20*1~
NM1*85*2* ABDSERVICE *****24*587654321~
HL*2*1*21*1~
NM1*IL*1*Doe*John****34*Z002211~
HL*3*2*22*1~
HI*BF:41090:D8:20030908*1101~
NM1*IL*1*Smith*Joe****MI*12345678901~
HL*4*3*19*1~
NM1*SJ*1*Watson*Susan****34*987654321~
PER*IC**TE*4029993456~
SE*184*284101503~

GE*1*284101503~

IEA*1*00905~

Transaction Set Level Syntax Results and X12N 999 Rejection Report

This edit is enforced by transaction set level syntax problems for all transactions within each functional group. These edits check the ST to SE level segments and the data content within these segments. These segments consist of the entire detailed information within a transaction. Any X12 syntax error that occurs at this level *will result in the entire transaction being rejected*. However, if the *functional group* consists of additional transactions without errors, these will be processed. The rejections are reported on an X12N 999.

X12N 999-Functional Acknowledgement

Xerox clearinghouse validates submission of ANSI ASC X12N format(s). An ANSI ASC X12N 999, or Functional Acknowledgement, is generated when an EDI file, e.g., an ANSI ASC X12N file that has passed the header and trailer check, passes through the clearinghouse. The X12N 999 contains **ACCEPT** or **REJECT** information; if the file contained syntactical errors, the segment(s) and element(s) where the error(s) occurred will be reported. For an example of this report, please see *ASC X12 TR3, Implementation Acknowledgment for Health Care Insurance (999)*. Trading Partner Agreement between Xerox EDI Gateway and the trading partners requires this method of acknowledgement.

EXAMPLE:

The following example was built with incorrect Payer ID. The Payer ID for Colorado Medicaid is 77016.

ISA*03* *00* *ZZ*100000 *ZZ*100000 *111026*1015*^*00501*00905*0*T*:~

GS*HC*100000*77016*20111026*101507*284101503*X*005010X223A2~

ST*837*284101503*005010X223A2~
NM1*PR*2*CO Medicaid*****P*__**77028**~__
HL*1**20*1~
NM1*85*2* ABDSERVICE *****24*587654321~
HL*2*1*21*1~
NM1*IL*1*Doe*John****MI*Z002211~
HL*3*2*22*1~
HI*BF:41090:D8:20030908*1101~
NM1*IL*1*Smith*Joe****MI*12345678901~
HL*4*3*19*1~
NM1*SJ*1*Watson*Susan****34*987654321~
PER*IC**TE*4029993456~
SE*12*0001~

ST*837*0001~
NM1*PR*2*CO Medicaid*****P*__**77028~**__
HL*1**20*1~
NM1*85*2* ABDSERVICE *****24*587654321~
HL*2*1*21*1~
NM1*IL*1*Doe*John****MI*Z000221~
HL*3*2*22*1~
HI*BF:41090:D8:20030908*1101~
NM1*IL*1*Smith*Joe****MI*12345678901~
HL*4*3*19*1~
NM1*SJ*1*Watson*Susan****34*987654321~
PER*IC**TE*4029993456~
SE*184*284101503~

GE*2*284101503~

IEA*1*00905~

Transaction Set Level Results and the Rejection Report

The edit is enforced by the TR3 rules for the particular transaction. The ST and SE level edits will vary depending on the rules set by the TR3, code sets, and looping structures. Any errors that occur at this level *will result in the data content within that claim being rejected.* However, if the *batch* consists of additional claims without errors, these will be processed. The rejection reports are not mandated to be in a specific format. The X12N 277CA is used during these instances.

X12N 277CA (Claim Acknowledgment)

For the Colorado Medical Assistance Program, the 277CA is generated when a payer submits an EDI transaction. This will occur for accepted transactions and for those that an edit occurs in the ST to SE segments at the TR3 level. If a business edit fails during the translation of the X12N 837 transaction, an X12N 277CA application response will be returned to the submitter. This is used to report errors outside of the scope of the X12N 999. It will detail what errors are present, and if necessary, what action the submitter should take. The ANSI ASC X12N 277CA will also be available as a print image for trading partner retrieval. The use of the X12N 277CA transaction is not required by HIPAA. For an example of this report, please see *ASC X12 TR3, Health Care Claim Acknowledgment (277)*.

Colorado Business Edits for the 837 Institutional

The list below contains current Colorado Medical Assistance Program Business edits. All 277CAs will be available for view and download on the BBS. The 277CA edits validate the **ST** and **SE** level segments and the data content within these segments for payer business edits.

1. Edit Failed - Loop 2010BA - NM109 - Subscriber ID
2. Edit Failed - Loop 2300 - HI - Invalid Diagnosis Qualifier ABK (ICD-10) Correct Qualifier is BK (ICD-9)
3. Edit Failed - Loop 2300 - DTP03 - Statement Date before Subscriber Birth Date
4. Edit Failed - Loop 2300 - CLM05-03 - Invalid Original TCN
5. Edit Failed - Loop 2300 - REF02 - Attending Provider ID not 8 bytes
6. Edit Failed - Loop 2410 - LIN03 - NDC must equal 11 bytes and must not contain alpha characters. (Alpha and special Characters are not allowed. Only numbers should be submitted in LIN03).
7. Edit Failed - BHT06 - Transaction Type Code

EXAMPLE:

The transaction was built with incorrect data segment. In loop 2010ba, nm109 contains all numerics. It should have one alpha character followed by 6 numbers or else it will return a 277ca to the trading partner.

ISA*03* *00* *ZZ*100000 *ZZ*100000 *111026*1015*^*00501*00905*0*T*:~
GS*HC*100000*77016*20111026*101507*284101503*X*005010X223A2~
ST*837*0021~
BHT*0019*00*0123*20030731*1023*CH~
REF*87*004010X098A1~
NM1*41*2*ABDSERVICE*****46*TGJ23~
PER*IC*JERRY*TE*3051112222*EX*000~
NM1*40*2*CO Medicaid*****46*77016~
HL*1**20*1~
NM1*85*2* ABDSERVICE *****24*587654321~
N3*234 Noway St~
N4*Miami*FL*33111~
NM1*87*2*KILDAREASSOC*****24*581234567~
N3*2345 OCEAN BLVD~
N4*MIAMI*FL*33111~
HL*2*1*22*0~
SBR*P*18*12312-A******MC~
NM1*IL*1*Doe*John****MI***1002211**~
N3*236 N MAIN ST~
N4*MIAMI*FL*33413~
DMG*D8*19430501*M~
NM1*PR*2*CO Medicaid*****PI*77016~
HI*BK:0340*BF:7389~
NM1*82*1*KILDARE*BEN****34*112233334~
PRV*PE*ZZ*203BF0100Y~
NM1*77*2*KILDARE ASSOCIATES*****24*581234567~
N3*2345 OCEAN BLVD~
N4*MIAMI*FL*33111~LX*1~
SV1*HC:99213*40*UN*1***1**N~
DTP*472*D8*19981003~LX*2~
SV1*HC:99214*15*UN*1***1**N~
DTP*472*D8*20030703~
LX*3~
SV1*HC:87072*35*UN*1***2**N~
DTP*472*D8*20030703~LX*4~
SE*36*0021~
GE*1*284101503~
IEA*1*00905~

For additional information regarding the TA1, please refer to Appendix B in the ANSI ASC X12 *Consolidated Guide Health Care Claim: Institutional (837).*

Accept/Reject Report

An Accept/Reject Report will be returned to the trading partner via the Colorado File and Reports Services. This is a pre-adjudication report detailing the likelihood of claim payment or denial.

X12N 835-Remittance Advice

An X12N 835 Remittance Advice may be requested. After claim adjudication, an X12N 835 Remittance Advice will be delivered to the Colorado Medical Assistance Program File and Reports Services. For further information, please see Chapter 4, Data Retrieval Methods. The ANSI ASC X12N 835 can contain information related to payees, payers, dollar amounts and payments. Please see *ASC X12 TR3, Health Care Claim Payment/Advice (835)* for details on the ANSI ASC X12N 835.

Chapter 4 Data Retrieval Methods

File and Reports Services

The State's Provider Web Portal will include a File and Reports Service (FRS) for file and report retrieval. Billing Agents and clearinghouses will have the option of retrieving the transaction responses and reports themselves and/or allowing each individual provider the option of retrieval. The trading partner will access the system using a login and password assigned to them. For information on the State's Provider Web Portal, go to the Provider Services Web Portal section of the Department's Web site at http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1201542697178.

Chapter 5 Testing & General Submitting Guidelines

Completion of the testing process must occur prior to electronic submission to Xerox EDI Gateway. Assistance from the EDI Support Unit is available throughout this process. Each test transmission is inspected thoroughly to ensure no format errors are present. Testing is conducted to verify the integrity of the format, not the integrity of the data; however, in order to simulate a production environment, we request that you send real transmission data. The number of test transmissions required depends on the number of format errors on a transmission and the relative severity of these errors. Additional testing may be required in the future to verify any changes made to Xerox's system. Also, changes to the ANSI formats may require additional testing.

In order to expedite testing, Xerox EDI Gateway requires providers to submit all X12N test transactions to EDIFECS prior to submitting them to Xerox EDI Gateway. The EDIFECS service is free to providers for Colorado Medical Assistance Program to certify X12N readiness. EDIFECS offers submission and rapid result turn-around 24 hours a day, 7 days a week. For more information, providers can log on to http://www.hipaadesk.com/. During Pilot Submitter Testing an EDI Support Unit representative may be contacted at 1-800-237-0757 to answer questions related to EDIFECS, testing, enrollment, and companion guides.

Pilot Submitter Testing Procedure

After the initial phone interview with the pilot submitter, the EDI Support Unit representative will direct the pilot submitter to the EDIFECS Web site where the submitter may deliver their X12N test files for analysis. Each test file will be analyzed based on the seven types of testing defined by WEDI SNIP. The submitter will be required to address any errors discovered by EDIFECS during this interrogation before moving on to the next stage of testing with the clearinghouse. After EDIFECS has approved each test file for a particular pilot submitter, the EDI Support Unit representative will schedule a communications test with each pilot submitter. The EDI Support Unit representative will work with them to verify connectivity with both the clearinghouse and the Host Data Exchange (HDE) following successful completion of this test effort, a testing schedule will be established for each pilot submitter.

Upon receipt of the test files, the EDI Support Unit representative will track each file through the clearinghouse to ensure that all data is transformed properly, and all functions within the clearinghouse are working as designed. The EDI Support Unit representative will advise the pilot submitter of any problems with the content of the test file, as well as, any problems within the clearinghouse that are discovered during this test phase. If issues are discovered that require a change within the clearinghouse, a second round of testing will be scheduled with that pilot submitter. The timeframe for retest will be dependent on the complexity of the change needed, as well as consideration for the appropriate amount of time needed for unit, systems, and regression testing.

The next stage of pilot submitter testing will occur after all issues have been resolved and all test files have been successfully executed by a particular pilot submitter. At this point, the test file will be run through the clearinghouse and delivered on through to the Colorado Medical Assistance Program Management Information System (MMIS) for processing. The MMIS testing team will provide feedback to the EDI Support Unit representative who will in turn keep pilot submitters updated on the status of their test files.

The EDI Support Unit representative will also verify that the pilot submitter does not have any additional questions or concerns before completing the test.

General Testing Procedures for Trading Partners

Trading partner testing is designed to ensure transactions submitted to Xerox EDI Gateway are properly formatted and may be processed through the clearinghouse system to the Colorado MMIS.

Software vendors are required to test all transactions supported by their products successfully before distributing their products for use. Trading partners that elect to use an approved software vendor are exempt from testing.

Trading partner testing will consist of a combination of clearinghouse error checks by an EDI Support Unit representative. These tests verify a trading partner's ability to submit a specific transaction type containing valid data in the required format. Once all tests are passed, the partner is approved for production.

General Production Submission Guidelines for Trading Partners

Submitting Fee for Service Claims:

- Submit a maximum total of 5,000 Claims in each Batch.
- Submit Batches containing greater than 2,500 Claims after 5:00 MST.
- Submit a maximum total of 25,000 Claims daily.

Submitting Encounters:

- Submit Encounters **Saturday through Thursday**.
- Do NOT submit **Encounters on Friday.**
- Submit a maximum total of 5,000 Encounters in each Batch.
- Submit Batches containing greater than 2,500 Encounters after 5:00 MST.
- Submit a maximum total of 25,000 Encounters daily.

Chapter 6 Payer Specific Data

EDI Support

Xerox has an Electronic Data Interchange (EDI) Support Unit to assist providers and trading partners with their questions and concerns about EDI. The following is a list of services that are provided by the EDI Support Unit:

- Assistance with enrollment
- Explanation of the various EDI submission methods
- Assistance with EDI transmission problems
- Assistance with approved software vendor verification

The EDI Support Unit is available to all Colorado Medical Assistance Program clients and providers Monday through Friday from 8:00 a.m. to 5:00 p.m. MT at 1-800-237-0757.

Enrollment Information

Any entity sending an electronic eligibility verification request to Xerox EDI Gateway for processing where reports and responses will be delivered must complete a Provider Enrollment package or Submitter Enrollment package. This package provides the information necessary to assign a Logon Name, Logon ID, and Trading Partner ID, which are required to submit electronic eligibility verification request submission. You may obtain an enrollment package by contacting XEROX State Healthcare at 1-800-237-0757 or by downloading it from the Provider Services Enrollment section of the Department's Web site at http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1201542696393.

Acrobat Reader supports this form. It must be printed, completed and mailed or faxed to the appropriate address /fax number listed on the form.

Transmission Telephone Number

Xerox provides availability for claims transmission 24 hours a day, 7 days a week. There are no restrictions on the number of claims or the frequency of transmissions. The claims transmission telephone numbers are 1.800.334.2832 or 1.800.334.4650.

Tracking Transmission/Production Problems

Please have the following information available when calling the EDI Support Unit regarding transmission and production issues.

Trading Partner ID: Your Trading Partner ID is our key to accessing your trading partner information. Please have this number available each time you contact the EDI Support Unit.

Logon Name and Logon User ID: These allow asynchronous trading partners access to the host system for claims submission. The EDI Support Unit uses this information to reference your submitted data.

Highlights

To promote efficient, accurate electronic claims processing, please note:

- Each user is assigned a Xerox EDI Trading Partner ID.
- Logon User IDs (passwords) are nine characters.
- All dates are in the CCYYMMDD format.
- All date/times are in the CCYYMMDDHHMM format.
- The same phone number will be used for transmitting test and production.
- Colorado Medical Assistance Program Provider IDs are eight characters long.
- The EDI Gateway assigned Payer ID for Colorado Medical Assistance Program is 77016.

Chapter 7 X12N 837 Health Care Claim Institutional – V5010.A1

This section contains data clarifications. The clarifications include:

- Identifiers to use when a national standard has not been adopted
- Parameters in the TR3 that provide options.

Many of the data elements included in the Companion Guides are business requirements and are not standardization-required elements. Inclusion of a "business-required" data field, as defined by this Companion Guide, may aid in the delivery of a positive response.

Please note the page numbers listed below in each of the tables represent the corresponding page number in the TR3 for this transaction.

X12N 837 Health Care Claim: Institutional

*The below mentioned Loops, Segments and Data Elements are for Colorado Medicaid specifically. For additional information regarding the X12 5010 format, please refer to the TR3 implementation guide.

*PAGE	LOOP	SEGMENT	DATA ELEMENT	COMMENTS
C.3	Interchange Control Header	ISA	01	Enter **'00'**
C.4	Interchange Control Header	ISA	02	Enter 10 blank spaces
C.4	Interchange Control Header	ISA	03	Enter **'00'**
C.4	Interchange Control Header	ISA	04	Enter 10 blank spaces
C.4	Interchange Control Header	ISA	05	Enter **'ZZ'**
C.4	Interchange Control Header	ISA	06	Enter your Xerox EDI Trading Partner ID
C.4	Interchange Control Header	ISA	07	Enter **'ZZ'**
C.5	Interchange Control Header	ISA	08	**Enter '100000'**
C.7	Functional Group Header	GS	02	Your Xerox EDI Trading Partner ID will be returned on the 837I transaction

*PAGE	LOOP	SEGMENT	DATA ELEMENT	COMMENTS
C.7	Functional Group Header	GS	03	Enter '77016' - The code identifying the receiving entity-Colorado Medicaid
77	1000B	NM1	03	Enter '**CO Medicaid**'
77	1000B	NM1	09	Enter '**77016**'
90	2010AA	REF	02	Billing Provider Tax Identification Number Enter the 8-digit Colorado Medical Assistance Program Billing Provider ID. This element is required for CO Medical Assistance Program claims processing For Managed Care Organization Encounter claims– enter the Medical Assistance Program Provider ID of the appropriate provider type (based upon the type of claim being submitted) assigned to the Managed Care Organization billing the claim.
108	2000B	HL	04	Enter '**0**' The Subscriber is always the patient; therefore, the dependent level will not be utilized
110	2000B	SBR	09	Enter '**MC**' This element is required for CO Medical Assistance Program claims processing.
114	2010BA	NM1	09	Enter the 7-digit Colorado Medical Assistance Program Client ID. This element is required for CO Medical Assistance Program claims processing
146	2300	CLM	01	Enter the Patient Control Number. For Managed Care Organization Encounter claims, enter the TCN number internal to the Managed Care Organization submitting the claim.

*PAGE	LOOP	SEGMENT	DATA ELEMENT	COMMENTS
149	2300	CLM	20	If applicable, Enter this element to identify the reason the claim does not meet timely filing requirements. Valid Colorado Medical Assistance Program late bill override reasons include: 1 3 7 8 9 11 If one of these codes is used, the 2300/NTE segment must contain the applicable date and additional data regarding the delay. If the 2300/NTE is missing when it is required, this will cause your transaction to be rejected.
167	2300	REF	02	Enter the 7-digit Colorado Medical Assistance Program Prior Authorization Number.
223-233	2300	HI	01-2 through 08-2	Only the first 8 other diagnosis codes sent in HI01-2 through HI08-2 will be used for claims processing by the Colorado Medical Assistance Program.
242	2300	HI	01-2	A Principal Procedure Code can be entered when performed. Note: A total of 6 surgical procedure codes, including the Principal Procedure code and 5 Other Procedure Codes will be used for claims processing by the Colorado Medical Assistance Program.

*PAGE	LOOP	SEGMENT	DATA ELEMENT	COMMENTS
245-250	2300	HI	01-2 Through 05-2	Only the first 5 Other Procedure Codes sent in HI01-2 through HI05-2 will be used for claims processing by the Colorado Medical Assistance Program. (For a total of 6 surgical procedure codes, including the primary procedure code). Note: A total of 6 Procedure Codes, including the Principal Procedure Code and 5 Other Procedure Codes will be used for claims processing by the Colorado Medical Assistance Program.
260-261	2300	HI	01-1 Through 02-1	Enter '**BI**' when applicable. Note: Only the first 2 Occurrence Span Codes sent in the first repeat of this segment in HI01-2 and HI02-2 will be used for claims processing by the Colorado Medical Assistance Program.
260-261	2300	HI	01-2 Through 02-2	Enter the Occurrence Span when applicable. Note: Only the first 2 Occurrence Span Codes sent in the first repeat of this segment in HI01-2 and HI02-2 will be used for claims processing by the Colorado Medical Assistance Program.

*PAGE	LOOP	SEGMENT	DATA ELEMENT	COMMENTS
273-281	2300	HI	01-1 Through 08-1	Enter the '**BH**' when applicable. **Note:** Only the first 8 Occurrence Codes/Dates sent in the first repeat of this segment in HI 01-2 through HI 08-2 will be used for claims processing by the Colorado Medical Assistance Program. **Note** – If the Delay Reason Code is used in Loop 2300/CLM20 or if this is a coordination of benefits (COB) claim with TPL and/or Medicare data, fewer Occurrence Codes sent in this loop will be used. The number of occurrence codes sent in this case will range from 5 to 7, depending on the situation.
273-281	2300	HI	01-2	Enter the Occurrence Code when applicable. *Note:* Only the first 8 Occurrence Codes/Dates sent in the first repeat of this segment in HI 01-2 through HI 08-2 will be used for claims processing by the Colorado Medical Assistance Program. **Note** – If the Delay Reason Code is used in Loop 2300/CLM20 or if this is a coordination of benefits (COB) claim with TPL and/or Medicare data, fewer Occurrence Codes sent in this loop will be used. The number of occurrence codes sent in this case will range from 5 to 7, depending on the situation.
356	2320	SBR		Provide Third Party and Medicare Crossover information in this loop. Uses one repeat of the loop for each non-Medical Assistance Program payer

*PAGE	LOOP	SEGMENT	DATA ELEMENT	COMMENTS
359	2320	SBR	09	Enter '**MA**' or Enter '**MB**' For TPL, use the code, which correctly identifies the type of coverage provided by the policy. **Do not use code 'MC'** The Colorado Medical Assistance Program will consider up to two non-Medical Assistance Program payers for claims processing, in the order sent For Managed Care Organization Encounter claims – enter **'ZZ'** to identify the submitting MCO as a Payer on the claim.
	2400	SV2	05	Enter Service Unit Counts in whole numbers. Colorado Medicaid does not recognize any digits following the decimal point. Anything after the decimal point will be ignored.

Revision History

VERSION	DATE	DESCRIPTION/LOCATION OF CHANGE
1.1	02/09/15	PR #2977: Updated Chapter 3, Section X12N 277CA. Added business edit as follows: "Edit Failed - Loop 2300 - HI - Invalid Diagnosis Qualifier ABK (ICD-10) Correct Qualifier is BK (ICD-9)"